

MEDICAL ASSISTANCE ADMINISTRATION
VISION CARE LIMITATION EXTENSION

PROVIDER INFORMATION		
PROVIDER NAME		DSHS PROVIDER NUMBER
TELEPHONE NUMBER	FAX NUMBER	
CLIENT INFORMATION		
CLIENT NAME		PIC NUMBER
SERVICE REQUEST INFORMATION		
PROCEDURE CODE	DATE	
Description of service/item being requested:		
IF CONTACT LENS:		
Type and Quantity	Length of time	
Why is a Limitation Extension being requested?		
MEDICAL INFORMATION		
Related ocular or medical diagnosis:	Dx	ICD
	Dx	ICD
What is the medical justification for this request?		
How will approval of this request functionally benefit the client?		
Is there a less costly alternative? What is it? Why won't it work for this client?		

DSHS 13-739 (11/2004)

Must be attached to this request:

- **Date of last dispense of glasses and/or contacts**
- **Copy of prescription**
- **Copy of previous prescription**

Fax: **360-586-1471** or mail to: Medical Request Coordinator, MAA/DMM
PO Box 45506
Olympia, WA 98504-5506